

can be established and used for support of persons with life-limiting illnesses.

2. Describe why this model of care may be particularly relevant to palliative care and hospice populations.
3. Describe the preliminary results of a randomized control trial to test the effectiveness of this informal care model.

I. Background. Recent studies have documented marked physical and psychological burden experienced by caregivers of persons with life-limiting illnesses. Practical, effective, and sustainable interventions are needed to better support caregivers.

II. Research Objectives. Assess the impact of Share The Care™—an informal, community-based caregiver support model—on caregiver and care-receiver outcomes, including perceived burden, satisfaction and quality of life, and health resource utilization.

III. Methods. Randomized control trial of care dyads (caregiver and care recipient) receiving assistance in forming Share The Care™ groups versus dyads receiving care from a managed care organization's usual support services. This model uses a trained facilitator to organize a patient/caregiver's friends, relatives, neighbors, and co-workers into a group that provides structured, practical assistance to the caregiver.

Measurable outcomes include caregiver strain, care-recipient efficacy, the incidence of depression, and self-reported health status in both caregiver and care recipient. Utilization of health-care services will also be measured.

IV. Results. Although the study is still currently enrolling patients, authors plan to present baseline demographics and baseline results for caregiver strain, care-recipient efficacy, the incidence of depression, and self-reported health status in both caregivers and care recipients.

V. Conclusions. While there are not yet study-specific conclusions, authors will describe the model structure and preliminary data, and relate findings to caregiver support in palliative care and hospice settings.

VI. Implications for research, policy, or practice. This pilot study examines the feasibility and outcomes of a practical caregiver support model. The theoretical advantage of this informal network model is that it does not require caregivers to engage in classes or other activities that paradoxically reduce time devoted to the care recipient or themselves. The model also appears to have theoretical sustainability advantages in that the group does not

need ongoing outside assistance or oversight following initial facilitated group formation and organization.

A Palliative Care/Medical Intensive Care Telemedicine Program to Improve Rural Health Care (761)

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Objectives

1. Describe the process of developing a palliative care/medical intensive care unit telemedicine program.
2. Learn how to prepare for a palliative care/MICU preadmission teleconference by reviewing illustrative case reports.

I. Background. Fletcher Allen Health Care (FAHC) in Burlington, VT, is the only tertiary care center for a large area of upstate New York, New Hampshire, and Vermont. FAHC accepts critically ill patients from outlying hospitals without hesitation, even when its critical-care resources are overburdened. The FAHC medical intensive care unit has 900 admissions per year, 20% of which are direct transfers from rural hospitals in our region. Approximately one in five patients transferred from outlying hospitals to FAHC has a poor prognosis for survival, known at the time of transfer. Fletcher Allen Health Care has established telemedicine units in the majority of its referral hospitals, primarily to assist in stabilization of trauma patients prior to transfer. In March 2008, a telemedicine project was begun to provide additional support to our referring hospitals when transfer to our medical intensive care unit (MICU) of a patient who may not survive the hospital stay is anticipated. When such a patient is referred to the MICU, a telemedicine conference is conducted with the patient or family, referring physician, and the FAHC-MICU attending and palliative care physician prior to transfer.

II. Aims. The goal of this program is to improve communication and quality of care for patients transferred to the MICU with conditions they may not survive. Since palliative care programs have developed primarily in tertiary care settings, telemedicine has the potential to provide this expertise to community hospitals.

III. Methods/Session Descriptions. The methods used to develop clinical criteria for inclusion in the telemedicine project will be reviewed. Case reports will be used to describe how to prepare

for a palliative care/MICU preadmission teleconference. The limitations of telemedicine palliative care consultation will be discussed.

Family Caregiver Perspectives on Symptom Assessment and Management for Patients Dying from Respiratory Failure Due to Cystic Fibrosis (762)

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Objectives

1. Recognize that uncomfortable symptoms are common in patients dying from cystic fibrosis.
2. Family caregivers may have difficulty assessing symptoms and may be accepting of suboptimal symptom control in dying patients.

I. Background. Most patients with cystic fibrosis (CF) die from respiratory failure. Dyspnea, pain, and fatigue increase as lung disease progresses. Fear of medication-induced respiratory depression may lead to suboptimal symptom control in dying patients.

II. Research Objectives. We aimed to describe perspectives of family caregivers on symptoms experienced by dying CF patients.

III. Methods. Family caregivers of deceased CF patients participate in semi-structured interviews about treatments at the end of life, including assessment and management of symptoms such as dyspnea, pain, and fatigue. Medication use was verified using chart review. Descriptive statistics were used to summarize responses to multiple-choice questions, and transcripts were examined for predominant themes and illustrative quotes.

IV. Results. Thirty-six respondents answered questions about patients' symptoms in the last week of life. Six (17%) patients treated with mechanical ventilation were too heavily sedated for respondents to assess their symptoms. Of the remaining 30 respondents, 28 (93%) reported dyspnea, 20 (67%) pain, and 25 (83%) bothersome fatigue. Seven (19%) recalled no inquiry by physicians about symptoms. The majority ($n = 20$; 67%) felt symptoms were "somewhat well controlled"; only 3 (10%) felt symptoms were "very well controlled." Nine (30%) remarked that "they (clinicians) did the best they could" with regard to symptom management. Respondents reported improved symptom control in some patients

who received narcotics (6 of 15 [40%]) and in a majority who received anxiolytics (4 of 5 [80%]). However, many did not recall that medications intended to provide comfort were administered. None reported feeling fearful of medications hastening death, but 9 (30%) described delaying use of medications until death was clearly imminent.

V. Conclusions. Uncomfortable symptoms are common in dying CF patients. Family caregivers are quite accepting of suboptimal symptom control.

VI. Implications for research, policy, or practice. Investigation of physician practices and attitudes may be helpful in developing recommendations for improved symptom assessment and management for patients dying from CF.

Impact of the Addition of a Pharmacist to an Existing Palliative Care Team (763)

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Objectives

1. Define the responsibilities of a palliative care pharmacist.
2. Review pain management and symptom management consults undertaken by the palliative care team pharmacist.
3. List types of interventions and report acceptance of recommendations made by the palliative care pharmacist.

I. Background. End-of-life issues present a complex set of challenges in providing an acceptable quality of life to a patient. The Center to Advance Palliative Care has developed the "Crosswalk of JCAHO Standards and Palliative Care," a document providing guidance on the establishment of an effective palliative care team consistent with Joint Commission standards. Treatment of chronic pain and managing associated symptoms of advanced illness is one of the palliative care team key processes identified in the document. This philosophy is also consistent with the appropriate delivery of pharmaceutical care, where quality care is improved by identifying, resolving, and preventing medication errors and improving outcomes related to drug therapy regimens.

II. Aims. At our institution, a pain management-trained pharmacist was added to an established palliative care team in order to provide expertise on pain and symptom management, an essential aspect of providing comfort to the patient. Patient, caregiver, and staff education